

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04493

446

CERTIFICATE OF DEATH

Reg. Dist. No.

282

1. PLACE OF DEATH a. COUNTY St Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hollywood		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hollywood		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Carroll Last Cusic		4. DATE OF DEATH Month April Day 25 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1943
9. AGE (In years last birthday) 12 yrs.		IF UNDER 1 YEAR Months 9 Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carroll Cusic		14. MOTHER'S MAIDEN NAME Gertrude B. Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Carroll Cusic		Address Hollywood, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cystic Fibrosis of pancreas (Exocriosis) 756.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Liver (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cystosis of liver		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Roy Guyther		M.D. Mechanicsville	
PHYSICIAN'S NAME (Type) Roy Guyther		M.D. Mechanicsville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/27/56	
22c. NAME OF CEMETERY OR CREMATORY St John's		22d. LOCATION (City, town, or county) (State) Hollywood, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly		ADDRESS Leonardtwn, Md.	
24a. REC'D BY REGISTRAR DATE 4/27/56		24b. REGISTRAR'S SIGNATURE Gloria D. Hauer	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		MAY 1 1956		BALTIMORE, MARYLAND	
AGE		SEX		RACE	
65		Male		White	
BIRTH DATE		BIRTH PLACE		MANNER OF DEATH	
MAY 1 1891		BALTIMORE, MARYLAND		Natural	
DISEASE		CAUSE OF DEATH		IMMEDIATE CAUSE	
Coronary Artery Disease		Myocardial Infarction		Coronary Artery Disease	
PREVIOUS ILLNESS		HISTORY OF PRESENT ILLNESS		TREATMENT	
None		Sudden onset of chest pain, radiating to the left arm and jaw, associated with sweating and nausea.		None	
OCCUPATION		EDUCATION		RELIGION	
None		None		None	
MARITAL STATUS		SINGLE		MARRIED	
None		None		None	
SIGNED BY		WITNESSED BY		DATE	
JAMES H. HARRIS		JAMES H. HARRIS		MAY 1 1956	

BUREAU V. S.

MAY 1 1956

RECEIVED

4407

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH a. COUNTY <u>St. Marys</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hollywood</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Island Creek</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Norace</u> Middle <u>W.</u> Last <u>Stenton</u>				4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 27, 1869</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Calvert Co., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Stenton</u>				14. MOTHER'S MAIDEN NAME <u>Maria ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Mrs Chester Joy - Hollywood, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arterio sclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>30 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov 10, 1955</u> to <u>April 4, 1956</u> that I last saw the deceased alive on <u>April 4, 1956</u> , and that death occurred at <u>10:36 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P J BEAN</u> M.D. <u>Great Mills Md</u>				DATE SIGNED <u>4/5/56</u>			
PHYSICIAN'S NAME (Type) <u>P J BEAN M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 7, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Watson Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Calvert County, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Thackness & Son - Mutual, Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>4/5/56</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. S.

APR 6 1956

RECEIVED

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		12/1/20		MEMPHIS, TENN.	
MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
MARRIED		4/4/56		MEMPHIS, TENN.		SHOOTING		SUICIDE		ATTORNEY	
EDUCATION		SCHOOLING		RELIGION		TENDENCY		HISTORY		REMARKS	
HIGH SCHOOL		12		METHODIST		NONE		NONE		FUGITIVE FROM JUSTICE	
MILITARY SERVICE		ARMY		BRANCH		RANK		DUTY STATION		REMARKS	
NONE		NONE		NONE		NONE		NONE		FUGITIVE FROM JUSTICE	
PREVIOUS DEATHS		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
NONE		NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF REGISTRAR		DATE		SIGNATURE OF DECEASED		DATE		SIGNATURE OF WITNESS		DATE	
JAMES EARL RAY		4/4/56		JAMES EARL RAY		4/4/56		JAMES EARL RAY		4/4/56	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4498

CERTIFICATE OF DEATH

04495

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lexington Park</u>			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mechanicsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Station Hospital, USNAS, Patuxent River, Maryland</u>				d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Edward KING</u>				4. DATE OF DEATH Month Day Year <u>April 13 1956</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negroid</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>20 Sept 1955</u>		9. AGE (In years last birthday) yrs. <u>6</u> IF UNDER 1 YEAR Months <u>24</u> IF UNDER 24 HRS. Days <u>4</u> Hours <u>13</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>			10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Palmer Arthur KING</u>				14. MOTHER'S MAIDEN NAME <u>Anna T. PRICE</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Anna T. KING, Mechanicsville, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, lobar</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>13 April, 1956</u> , to <u>13 April, 1956</u> , that I last saw the deceased alive on <u>13 April, 1956</u> , and that death occurred at <u>8:15 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Station Hospital, U.S. Naval Air Station, Patuxent River, Maryland</u> DATE SIGNED <u>13 Apr 56</u>									
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Station Hospital, U.S. Naval Air Station, Patuxent River, Maryland</u>									
PHYSICIAN'S NAME (Type) <u>J.L. BROCKMAN LT MC USNR</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/19/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Morganza, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Leonardtown, Md.</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>4/23/56</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		1928		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		HUSBAND'S OCCUPATION		MILITARY SERVICE	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		LABORER		LABORER		NONE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		INJURY		POISON		OTHER	
APRIL 4, 1968		MEMPHIS, TENNESSEE		SHOOTING		SUICIDE		HEART DISEASE		GUNSHOT		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. E.

APR 24 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04496

4499

CERTIFICATE OF DEATH

Reg. Dist. No.

282

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN (RURAL)		c. LENGTH OF STAY IN 1b 37yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN (RURAL)		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HAROLD Middle KNIGHT Last KNIGHT		4. DATE OF DEATH Month APRIL Day 24 Year 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 2 1891
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 6 Days 22 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Brooklyn N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY EDWARD KNIGHT		14. MOTHER'S MAIDEN NAME MARY ALICE KNIGHT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give year or date of service) WORLD WAR I		16. SOCIAL SECURITY NO. 217-18-1919	
17. INFORMANT MRS. HAROLD KNIGHT		Address LEONARDTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) inoperable DUE TO (c) Heart failure		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 Y.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 19 56 to 4-24-56 that I last saw the deceased alive on 4-20-56 , 19 56 , and that death occurred at 4:28 M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Michael Barbarich M.D.			
PHYSICIAN'S NAME (Type) MICHAEL BARBARICH M.D.		LEONARDTOWN MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/27/1956	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE CHARLES J. MATTINGLY		ADDRESS LEONARDTOWN, MD.	
24a. REC'D BY REGISTRAR DATE 4/26/56		24b. REGISTRAR'S SIGNATURE Glaude A. Hauer	

CERTIFICATE OF DEATH

PLACE TO BE FILLED BY THE REGISTRAR		PLACE TO BE FILLED BY THE DEATH REGISTRAR	
NAME OF DECEASED		NAME OF DECEASED	
AGE		AGE	
SEX		SEX	
RACE		RACE	
DATE OF DEATH		DATE OF DEATH	
TIME OF DEATH		TIME OF DEATH	
PLACE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
SIGNATURE OF REGISTRAR		SIGNATURE OF DEATH REGISTRAR	
DATE OF REGISTRATION		DATE OF REGISTRATION	
PLACE OF REGISTRATION		PLACE OF REGISTRATION	
NAME OF REGISTRAR		NAME OF DEATH REGISTRAR	
ADDRESS OF REGISTRAR		ADDRESS OF DEATH REGISTRAR	
CITY OF REGISTRAR		CITY OF DEATH REGISTRAR	
STATE OF REGISTRAR		STATE OF DEATH REGISTRAR	
COUNTRY OF REGISTRAR		COUNTRY OF DEATH REGISTRAR	
DATE OF BIRTH		DATE OF BIRTH	
TIME OF BIRTH		TIME OF BIRTH	
PLACE OF BIRTH		PLACE OF BIRTH	
CAUSE OF BIRTH		CAUSE OF BIRTH	
MANNER OF BIRTH		MANNER OF BIRTH	
SIGNATURE OF BIRTH REGISTRAR		SIGNATURE OF BIRTH REGISTRAR	
DATE OF BIRTH REGISTRATION		DATE OF BIRTH REGISTRATION	
PLACE OF BIRTH REGISTRATION		PLACE OF BIRTH REGISTRATION	
NAME OF BIRTH REGISTRAR		NAME OF BIRTH REGISTRAR	
ADDRESS OF BIRTH REGISTRAR		ADDRESS OF BIRTH REGISTRAR	
CITY OF BIRTH REGISTRAR		CITY OF BIRTH REGISTRAR	
STATE OF BIRTH REGISTRAR		STATE OF BIRTH REGISTRAR	
COUNTRY OF BIRTH REGISTRAR		COUNTRY OF BIRTH REGISTRAR	

10/11

BUREAU V. 8

APR 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4410

CERTIFICATE OF DEATH

Reg. Dist. No.

284

1. PLACE OF DEATH a. COUNTY <u>St. Marys</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Marys</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlotte Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlotte Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Theressa</u> Middle <u>Lotepich</u> Last <u></u>		4. DATE OF DEATH Month <u>4</u> Day <u>2</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/17/1886</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Lotepich</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Feiner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Reginald Lotepich</u> Address <u>Charlotte Hall</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>203X Plasma cell myeloma with</u> DUE TO <u>extensive metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pathologic fractures, femur, ribs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/24</u> , 19 <u>53</u> , to <u>4/10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/30</u> , 19 <u>56</u> , and that death occurred at <u>8:00 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Roy Guyther</u> M.D.		ADDRESS (Street, city or town, state) <u>Mechanicsville, Md</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>J. Roy Guyther, M.D.</u>		<u>Mechanicsville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/11/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>	22d. LOCATION (City, town, or county) (State) <u>Berensstown Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Reginald Lotepich Home Address, Md</u> ADDRESS		24a. REC'D BY REGISTRAR <u>181555</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>E. Earl Canters</u>	

BUREAU V. B.

APR 12 1956

RECEIVED

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1. NAME OF DECEASED [Faint text]		2. DATE OF DEATH [Faint text]	
3. PLACE OF DEATH [Faint text]		4. CAUSE OF DEATH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. DATE OF BIRTH [Faint text]	
7. SEX [Faint text]		8. RACE [Faint text]	
9. OCCUPATION [Faint text]		10. MARITAL STATUS [Faint text]	
11. SIGNATURE OF DECEASED [Faint text]		12. SIGNATURE OF WITNESS [Faint text]	
13. SIGNATURE OF DECEASED [Faint text]		14. SIGNATURE OF WITNESS [Faint text]	
15. SIGNATURE OF DECEASED [Faint text]		16. SIGNATURE OF WITNESS [Faint text]	
17. SIGNATURE OF DECEASED [Faint text]		18. SIGNATURE OF WITNESS [Faint text]	
19. SIGNATURE OF DECEASED [Faint text]		20. SIGNATURE OF WITNESS [Faint text]	
21. SIGNATURE OF DECEASED [Faint text]		22. SIGNATURE OF WITNESS [Faint text]	
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83. SIGNATURE OF DECEASED [Faint text]		84. SIGNATURE OF WITNESS [Faint text]	
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87. SIGNATURE OF DECEASED [Faint text]		88. SIGNATURE OF WITNESS [Faint text]	
89. SIGNATURE OF DECEASED [Faint text]		90. SIGNATURE OF WITNESS [Faint text]	
91. SIGNATURE OF DECEASED [Faint text]		92. SIGNATURE OF WITNESS [Faint text]	
93. SIGNATURE OF DECEASED [Faint text]		94. SIGNATURE OF WITNESS [Faint text]	
95. SIGNATURE OF DECEASED [Faint text]		96. SIGNATURE OF WITNESS [Faint text]	
97. SIGNATURE OF DECEASED [Faint text]		98. SIGNATURE OF WITNESS [Faint text]	
99. SIGNATURE OF DECEASED [Faint text]		100. SIGNATURE OF WITNESS [Faint text]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4411

CERTIFICATE OF DEATH

Reg. Dist. No.

04408

282

1. PLACE OF DEATH a. COUNTY ST MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MORGANZA		c. LENGTH OF STAY IN 1b 34 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LOUIS Middle JOHNSON Last MATTINGLY		4. DATE OF DEATH Month APRIL Day 21 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 15, 1888
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 4 Days 6 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM L. J. MATTINGLY		14. MOTHER'S MAIDEN NAME SOPHIA JOHNSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217 36 6328	
17. INFORMANT Lillian Mattingly Morganza, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2nd emic		INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 2:40 a.m. 4 21 1956 p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1956 to April 1956 , that I last saw the deceased alive on 20 Apr 56 , and that death occurred at 2:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Roy J. Guyther M.D.		M.D.	
PHYSICIAN'S NAME (Type) Roy J. Guyther M.D.		Mechanicsville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/24/56	22c. NAME OF CEMETERY OR CREMATORY ST Joseph's	22d. LOCATION (City, town, or county) (State) Morganza, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE 4/23/56	
		24b. REGISTRAR'S SIGNATURE Charles J. Mattingly	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JOHN J. JOHNSON		35		M		W		1920		BALTIMORE		MD		USA		USA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		SINGLE	
APR 24 1956		BALTIMORE		HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		CATHOLIC		MARRIED		MARRIED	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. E.

APR 24 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04499

4412

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>St. Mary's</u>		MARYLAND		STATE <u>New Jersey</u>		COUNTY <u>✓</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lexington Park</u>		LENGTH OF STAY (in this place) <u>9 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Yardville (Rural)</u>		<u>67X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Station Hospital, USNAS, Patuxent River, Maryland</u>				STREET ADDRESS (If rural give location) <u>Route #156</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Wayne Joseph McMahon</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 9 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>11-25-37</u>	9. AGE last birthday <u>18</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Moses McMahon</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes 1-25-55</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>U.S. Navy Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
911.3 IMMEDIATE CAUSE (A) <u>Injuries, multiple, extreme</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Naval Air Station</u>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>U.S. Naval Air Station, Patuxent River, Md.</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>U.S. Naval Air Station, Patuxent River, Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>April 9 1956 7:15 P.M.</u>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Forklift overturned while driving.</u>			
22. I hereby certify that I attended the deceased from <u>April 9</u> , 19 <u>56</u> , to <u>April 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 9</u> , 19 <u>56</u> , and that death occurred at <u>7:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>G.W. Taggart</u> G.W. TAGGART LT MC USN				ADDRESS (Street, city, town, state) <u>Station Hospital, U.S. Naval Air Station, Patuxent River, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Transportation</u>		DATE THEREOF <u>4/12/56</u>		NAME OF CEMETERY OR CREMATORY <u>Trenton, New Jersey</u>		DATE SIGNED <u>April 9 1956</u>	
24. REC'D BY REGISTRAR <u>4/12/56</u>		REGISTRAR'S SIGNATURE <u>Leon D. Houser</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson</u>		ADDRESS <u>Leonardtwn, Md.</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

NAME OF DECEASED

MARYLAND

CITY OF BALTIMORE

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BUREAU V. S.

APR 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04410

4413

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARK HALL				c. LENGTH OF STAY IN 1b 9 mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RURAL				d. STREET ADDRESS RURAL			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ADAM Middle LEROY Last MOWEN				4. DATE OF DEATH Month APRIL Day 20 Year 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 4, 1888		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY AUTOMOTIVE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ADAM RENNER MOWEN				14. MOTHER'S MAIDEN NAME MARY ANN HILL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. *****		17. INFORMANT Address BLAINE A. MOWEN - PARK HALL, MARYLAND.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							INTERVAL BETWEEN ONSET AND DEATH immediate
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from death to last seen , that I last saw the deceased alive on 12 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 4/20/56 ACTUAL SIGNATURE Julian S. Lane M.D. PHYSICIAN'S NAME (Type) Julian S. Lane							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/23/56		22c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) HAGERSTOWN, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE REST HAVEN FUNERAL CHAPEL, INC.				ADDRESS HAGERSTOWN, MD.		24a. REC'D BY REGISTRAR DATE 4/23/56	
				24b. REGISTRAR'S SIGNATURE Alvan D. Hanner			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4414 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04411

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <u>D.C., Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Great Mills</u>		c. LENGTH OF STAY IN 1b <u>9 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 21 D.C.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6753 Indian Head Rd</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Daniel</u> Last <u>Owen</u>				4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/13/1906</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gravel Pit</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James D Owen</u>				14. MOTHER'S MAIDEN NAME <u>Kate Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>224-05-7890</u>		17. INFORMANT <u>Thelma T. Owen</u> Address <u>753 Indian Head Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Confused fracture of skull</u> 835X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>run over by gravel truck</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>6:30</u> p. m. <u>4:27</u> 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Gravel pit</u>		20f. (City or town) (County) (State) <u>Great Mills St. Mary's Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Julian S. Lane</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Julian S. Lane</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Mattingly</u>				ADDRESS <u>Lionsdutton, Md</u>		24a. REC'D BY REGISTRAR DATE <u>4/30/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Glen D. Houser</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V.S.

1956 MAY 1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04412

4415

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MORGANZA				c. LENGTH OF STAY IN 1b 73 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 03				d. STREET ADDRESS MORGANZA			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last WILLIE CATHERINE RUSSELL				4. DATE OF DEATH Month Day Year APRIL 24 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 26 1861	9. AGE (In years last birthday) 94 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 10 28	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Lee				14. MOTHER'S MAIDEN NAME Martha Jane Washington Abell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Lee Russell Morganza Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Arterio-sclerotic CV disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prob. dissecting aneurysm of abdominal aorta DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 30 yrs 36 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1948 to April 24, 1956 , that I last saw the deceased alive on April 23, 1956 , and that death occurred at 10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. ROY GUYTHER M.D.				ADDRESS [Street, city or town, state] Mechanicsville Md. DATE SIGNED 4/24/56			
PHYSICIAN'S NAME (Type) J. ROY GUYTHER M.D.				MECHANICSVILLE MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 4/27/56		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY St. Joseph		22d. LOCATION (City, town, or county) (State) Morganza Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly				ADDRESS Leonardtwn Md.		24a. REC'D BY REGISTRAR DATE 4/26/56	
				24b. REGISTRAR'S SIGNATURE Glean D. House			

CERTIFICATE OF DEATH

PLACE OF BIRTH MARYLAND		PLACE OF DEATH MARYLAND	
DATE OF BIRTH 1911		DATE OF DEATH 1956	
SEX Male		SEX Male	
RACE White		RACE White	
OCCUPATION Farmer		OCCUPATION Farmer	
MARITAL STATUS Married		MARITAL STATUS Married	
NAME OF DECEASED William Lee Johnson		NAME OF DECEASED William Lee Johnson	
NAME OF NEXT OF KIN John Lee Johnson		NAME OF NEXT OF KIN John Lee Johnson	
ADDRESS 123 Main St, Baltimore, Md.		ADDRESS 123 Main St, Baltimore, Md.	
CAUSE OF DEATH Heart Disease		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. Lee Johnson		SIGNATURE OF PHYSICIAN J. Lee Johnson	
SIGNATURE OF WITNESS J. Lee Johnson		SIGNATURE OF WITNESS J. Lee Johnson	
SIGNATURE OF DECEASED William Lee Johnson		SIGNATURE OF DECEASED William Lee Johnson	

BUREAU V. S.

APR 27 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04413

4416
Item 9, Film G195, 4/10/56 bh
CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Scotland		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		d. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) First CALIP Middle DOUGLAS Last WHITE		4. DATE OF DEATH Month April Day 2 Year 19 56	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1882
9. AGE (In years last birthday) 77 ? yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Sea Food	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Murphy White		14. MOTHER'S MAIDEN NAME Lucy Medley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Helen E. White - Scotland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Edma of legs DUE TO (c) Broncho- pneumonia		INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/10 , 19 56 , to 4/2/ , 19 56 , that I lost saw the deceased olive on 4/2/ , 19 56 , and that death occurred at 10:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) California, Md. DATE SIGNED 4/3/56 ACTUAL SIGNATURE Edward B. Macon M.D. PHYSICIAN'S NAME (Type) Edward B. Macon, MD California, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/5/56	
22c. NAME OF CEMETERY OR CREMATORY ST. Lukes Cemetery		22d. LOCATION (City, town, or county) (State) Scotland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE 4/5/56	
24b. REGISTRAR'S SIGNATURE Ulean R. Houser			

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